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Tertiary paediatric hospital health professionals' attitudes to lesbian, gay, bisexual and transgender parents seeking health care for their children

Pam Nicol, Rose Chapman, Rochelle Watkins, Jeanine Young and Linda Shields

Aims and objectives. To ascertain health professionals' knowledge, attitudes and beliefs towards lesbian, gay, bisexual and transgender parents seeking health care for their children in a paediatric tertiary hospital setting which practises family-centred care.

Background. Lesbian, gay, bisexual and transgender parents are often reluctant to disclose their sexual orientation to health professionals for fear of discrimination and compromised quality of care. Staff knowledge, attitudes and beliefs can influence disclosure by parents, but little is known about knowledge, attitudes and beliefs in paediatric tertiary hospital staff towards lesbian, gay, bisexual and transgender parents accessing care for their children.

Design. Descriptive comparative study of health staff using a cross-sectional survey.

Methods. A set of validated anonymous questionnaires was used to assess knowledge about homosexuality, attitudes towards lesbians and gay men, and gay affirmative practice. Three open-ended questions were also used to assess beliefs about encouraging disclosure of lesbian, gay, bisexual and transgender parenting roles and how this may impact on care.

Results. Of the 646 staff surveyed, 212 (32·8%) responded. Knowledge and attitudes were significantly associated with professional group, gender, Caucasian race, political voting behaviour, presence of religious beliefs, the frequency of attendance at religious services, the frequency of praying, and having a friend who was openly lesbian, gay, bisexual and transgender.

Conclusion. This study highlighted that staff working in a tertiary paediatric hospital setting, with family-centred care models in place, held attitudes and beliefs that may impact on the experience of hospitalisation for lesbian, gay, bisexual and transgender parents, and the quality of care received by their children.

Relevance to clinical practice. To promote equitable care to all families, organisations should ensure that family-centred care policies and guidelines are adopted and appropriately implemented. In addition to formal education, affirmative health service action and innovative methods may be required.

Key words: attitudes, beliefs, family care, health professional knowledge, same sex parenting

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Introduction

Lesbian, gay, bisexual and transgender (LGBT) parents accessing health care for their children are often reluctant to disclose their sexual orientation to health professionals for fear of discrimination and compromised quality of care for themselves and their children (Perrin *et al.* 2004, Chapman *et al.* 2012a,b,c,d,e, Shields *et al.* 2012a,b). The consequences of nondisclosure can include leaving parents mistrusting, ill informed and can result in missed opportunities for health education (Perrin & Kulkin 1996, Chapman *et al.* 2012a,b,c,d,e). Moreover, this lack of trust in the relationship is likely to have a direct effect on reciprocity between the parent, child and health professionals. Trust and reciprocity are two characteristics of an environment that leads to support, cooperation and mutual benefit, which the social capital literature associates with better outcomes for children (Australian Institute of Health & Welfare 2010, p. 11).

Despite this clear association with outcomes for the child, there is little research on reasons for nondisclosure and lack of trust. However, it has been demonstrated that knowledge, attitudes and beliefs of health professionals regarding LGBT practices contribute to both LGBT parents' willingness to disclose their partnerships and to health professionals proactively encouraging disclosure (McNair & Perlesz 2004, Chapman *et al.* 2012a,b,c,d,e, Shields *et al.* 2012a,b).

A recent study in a second-level hospital found that the health professionals' knowledge, attitudes and beliefs regarding LGBT parents accessing health care for their children were poor (Chapman *et al.* 2012c). Consistent with other studies, the knowledge and attitude scores were significantly associated with race, religious beliefs, frequency of attendance at religious services and having a friend who is openly lesbian, gay, bisexual and transgender (Röndahl *et al.* 2004, Crisp 2006, Chapman *et al.* 2012c). The authors concluded that models that are inclusive of the child's family are ideal for LGBT parents seeking health care for their children, but the benefits can only be realised fully if health professionals delivering that care are sensitive to the context, functions and constructs of all the families they encounter (Chapman *et al.* 2012a,b,c,d,e).

Health services can promote inclusive practices by training staff caring for children in models of care that promote family involvement and respect for family diversity. In contrast to paediatric hospitals, where family-centred care often is advocated in hospital visions and policies, some second-level hospitals may not overtly include this framework in their vision and philosophy statements, stating respect for the individual instead. It is not necessarily that family models of care are not practised in these settings, but the influence of inclusion of the overt statements on attitudes and beliefs has not been quantified.

In contrast, in tertiary paediatric health services, the assumption could be made that those health professionals choosing to work in that environment would be child focussed and, therefore, aspire to practise within a model that is inclusive of family. Indeed, paediatric medical and nursing bodies have called for a philosophical perspective of care where the child is viewed as part of the family and the family is defined in the broadest context where the emphasis is on emotional rather than blood bonds Australian Confederation of Paediatric and Child Health Nurses (ACPCHN) 2000]. Moreover, health professionals are required to treat all families with respect and act to empower both the child and their family [Australian Confederation of Paediatric and Child Health Nurses (ACPCHN) 2000, Royal Australian College of Physicians (RACP), Paediatrics & Child Health Division 2008].

The competencies for paediatric and child health nurses in Australia adopt a 'philosophical perspective where the child is viewed within the context of the family, the family viewed in its broadest sense relying on bonds of emotional significance rather than direct progeny relationship' (Australian Confederation of Paediatric and Child Health Nurses (ACPCHN) 2000, p. 7]. Indicators of competency 1·2 include that the nurse 'maintains objectivity when confronted with differing values and beliefs; treats children and their families with respect; acts to empower the child and family' (Australian Confederation of Paediatric and Child Health Nurses (ACPCHN) 2000, p. 16]. Similarly, the Standards for the Care of Children and Adolescents in Health Services (2008) endorse the inclusion of, and respect for, families, in the child's care [Royal Australian College of Physicians (RACP), Paediatrics & Child Health Division 2008].

Therefore, given that educational attainment (possibly through reflective practice) has also been found to be a factor in knowledge and attitudes towards LGBT parenting, the educational experiences of health professionals in specialist paediatric practice ought to be a positive influence on knowledge and attitudes to diverse parenting styles, but this has not been tested. There is a paucity of evidence relating to paediatric tertiary hospital staff knowledge, attitudes and beliefs towards LBGT parents accessing care for their children.

In addition, increased interaction with people who are openly LGBT has been found a positive influence on

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knowledge and attitudes towards lesbian and gay practice (Dinkel *et al.* 2007, Yen *et al.* 2007, Chapman *et al.* 2012a,b,c,d,e). Given that there are larger numbers of parents seeking health care for their children in tertiary paediatric hospitals as compared to second-level hospitals, it could be hypothesised that staff in a paediatric tertiary hospital are more likely to have interacted with parents who are gay or lesbian than in second-level hospitals and are therefore more likely to be aware of and be more accepting of diversity. A study of the knowledge, attitude and beliefs of the staff in a specialist paediatric hospital may clarify the strength of this relationship and be useful in translation of the research into practice.

The purpose of this study was to ascertain health professionals' knowledge, attitudes and beliefs towards LGBT parents seeking health care for their children in a paediatric tertiary hospital setting. The results may help guide the development of educational and training programmes for paediatric health professionals, and affirmative health service policy that recognises and supports family diversity, including LGBT parenting. The findings will be of interest to paediatric hospitals seeking to evaluate an aspect of the family-centred standards of care policy and health professionals' competencies within their service.

Methods

Study design

This study used a cross-sectional survey design to describe health professionals' knowledge, attitudes and beliefs towards LGBT parents seeking health care for their children in a paediatric tertiary setting.

Setting, target population and sample

The sample was drawn from the all eligible health professionals (n = 746) working with children and families in a metropolitan paediatric tertiary referral centre in Australia. Eligibility criteria included being a nursing (registered or enrolled), allied health or medical professional, permanently or temporarily employed full time or part time, in participating inpatient and outpatient departments. All departments with direct family contact were included. Allied health included staff identifying with the disciplines of physiotherapy, speech pathology, occupational therapy, pharmacy, psychology, social work and audiology. Staff on sick, maternity, recreational or long service leave for more than 4 weeks during the data collection period were excluded.

Data collection procedure

In liaison with department managers, the roster schedule was used to identify current staff meeting eligibility criteria (n = 646) that included nursing (n = 412), medical (n = 134) and allied health (n = 100) staff members. Participants received a survey and information sheet distributed to participant mail points via the hospital's internal mail system. Consent was implied by the return of a completed questionnaire to the researchers via the addressed return envelope. Ethical approval for the study was granted from a university and the local hospital Human Research Ethics committee (HREC/11/QRCH/9).

Questionnaire

The questionnaire, which has been described elsewhere (Chapman *et al.* 2012b,e, e), collected basic sociodemographic data and assessed whether staff had friends who were openly LGBT and had ever cared for a child from an LGBT family. Three published scales were used to evaluate knowledge about homosexuality (Knowledge about Homosexuality Scale), attitudes towards lesbians and gay men (Attitude Toward Lesbians and Gay Men Scale) and the consistency of staff beliefs with gay affirmative practice (Gay Affirmative Practice Scale). All three scales have demonstrated high levels of internal consistency and have established construct validity (Herek 1994, Harris 1995, Crisp 2006). We were unable to locate published scales that collectively assessed attitudes to, and knowledge about, the broader construct of LGBT persons that were appropriate for use in this study and which had established psychometric properties (Chapman *et al.* 2012b,e). As such, three open-ended questions (as detailed in Table 4) were also included in the questionnaire to identify participants' thoughts, feelings and beliefs regarding LGBT parents accessing health care for their children.

Data analysis

Data were entered into SPSS, version 19 for analysis. A random 10% of records were compared with the original questionnaires to check the accuracy of data entry. Due to the skewed nature of the scale scores for attitudes and behaviour, we tested associations between variables using the chi-squared test of independence and differences between professional groups using the Mann–Whitney U-test or the Kruskal–Wallis one-way analysis of variance test. Correlations between continuous variables were described using Spearman's rank correlation coefficients,

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and all statistical tests were performed used two-tailed comparisons with a 95% level of confidence. The main content of responses to the open-ended questions was conceptualised and coded using standard content analysis methods (Speziale-Streubert & Carpenter 2003).

Results

Questionnaires were returned by 212 respondents, which included 142 (67·3%) nurses, 31 (14·6%) doctors, 38 (17·9%) allied health professionals or other staff, and one respondent (0·5%) who did not report their profession. The overall response rate was 32·8% (212/646).

The sociodemographic characteristics of the sample are summarised by professional group in Table 1. There was no significant difference in the age of respondents by professional group (Kruskal–Wallis $\chi^2 = 0{\cdot}2$, $p = 0{\cdot}92$) with similar mean ages for nurses (37·1 ± 11·3 years), doctors (35·9 ± 9·5 years), and allied health and other staff (37·4 ± 10·6 years). There was a significant difference between professional groups in the number of years in their profession (Kruskal–Wallis $\chi^2 = 6{\cdot}2$, $p = 0{\cdot}046$) and number of years in their current setting (Kruskal–Wallis $\chi^2 = 8{\cdot}3$, $p = 0{\cdot}02$). Nurses reported the longest mean duration serving in their profession (15·9 ± 11·7 years) compared with allied health and other staff (14·0 ± 10·4 years) and medical staff (10·1 ± 9·7 years). Nurses also reported the longest mean duration working in their current setting (7·8 ± 7·4 years) compared with allied health and other staff (6·7 ± 7·3 years) and doctors (5·2 ± 8·2 years).

Professional group was significantly associated with gender ($\chi^2 = 65{\cdot}8$, df = 2, $p < 0{\cdot}001$), employment status ($\chi^2 = 8{\cdot}5$, df = 2, $p = 0{\cdot}01$), Caucasian race ($\chi^2 = 11{\cdot}1$, df = 2, $p = 0{\cdot}004$) and reports of ever caring for a child from a LGBT family ($\chi^2 = 17{\cdot}2$, df = 2, $p < 0{\cdot}001$). Doctors were more likely to be male, work full time and non-Caucasian compared with other respondents. Allied health and other staff were less likely to report ever having cared for a child from a LGBT family (Table 1).

Knowledge, attitudes and gay affirmative practice beliefs

Mean knowledge, attitude and gay affirmative practice scores are summarised in Table 2 by sociodemographic characteristics and professional group. Age was not significantly correlated with knowledge ($r = 0{\cdot}04$, $p = 0{\cdot}56$), attitudes ($r = 0{\cdot}03$, $p = 0{\cdot}71$) or Gay Affirmative Practice (GAP) scores ($r = 0{\cdot}04$, $p = 0{\cdot}61$).

Of the 19 knowledge statements, 25·0% of nurses, 54·8% of doctors and 42·1% of allied and other health professionals identified approximately 90% (17) or more of the knowledge statements correctly. Knowledge scores were significantly associated with professional group, gender, Caucasian race, political voting behaviour, presence of religious beliefs, the frequency of attendance at religious services, the frequency of praying and having a friend who is openly LGBT (Table 2). The greatest differences between knowledge scores were found according to race and attendance at religious services, with the lowest levels of knowledge (mean scores of <70% of items correct) found among non Caucasian respondents and those who attended religious services at least weekly.

General attitudes towards lesbians and gay men differed significantly according to marital status, race, political voting behaviour, the presence of religious beliefs, the presence of Christian religious beliefs, the frequency of attendance at religious services, the frequency of praying and having a friend who is openly LGBT (Table 2). The most negative attitudes were found among respondents who reported attending religious services at least weekly, and those who reported not having a friend who is openly LGBT, closely followed by respondents who reported praying at least weekly and non Caucasian respondents. All variables were significantly associated with attitudes to both lesbians and gay men, except marital status which was only significantly associated with attitudes to gay men. (Table 3)

For the Gay Affirmative Practice (GAP) scale, 14·0% of nurses, 3·2% of doctors and 7·9% of allied and other health professionals received the maximum scale score; 52·2% of nurses, 36·7% of doctors and 56·8% of allied and other health professionals scored 50 or more out of possible 60, indicating that approximately half of respondents hold beliefs that are consistent with gay affirmative practice. There was a weak positive correlation between knowledge scores and GAP scores ($r = 0{\cdot}22$, $p = 0{\cdot}001$). In comparison, GAP scores were more strongly associated with attitudes ($r = -0{\cdot}43$, $p < 0{\cdot}001$), indicating that more positive attitudes are also associated with reporting beliefs consistent with gay affirmative practice. There was also a moderate negative correlation between attitude and knowledge scores ($r = -0{\cdot}40$, $p < 0{\cdot}001$), indicating increased knowledge is associated with more positive attitudes, as reflected by lower attitude scores.

Beliefs about LGBT parents seeking health care for their children

Responses to the three open-ended questions are summarised in Table 4. Doctors were less likely to specifically encourage disclosure of LGBT parenting roles (57·7%) than

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Table 1 Sample sociodemographic characteristics by professional group

Characteristic	Nurses (n = 142) n (%)	Doctors (n = 31) n (%)	Other (n = 38) n (%)	Total sample (n = 211) n (%)
Gender				
Female	131 (92·3)	11 (36·7)	36 (97·3)	178 (85·2)
Male	11 (7·7)	19 (63·3)	1 (2·7)	31 (14·8)
Highest qualification				
≤ Undergraduate degree	77 (54·2)	19 (61·3)	26 (68·4)	122 (57·8)
Postgraduate degree	65 (45·8)	12 (38·7)	12 (31·6)	89 (42·2)
Work hours				
Full time	87 (63·0)	27 (90·0)	23 (62·2)	137 (66·8)
Part time or casual	51 (37·0)	3 (10·0)	14 (37·8)	68 (33·2)
Marital status				
Married	84 (59·2)	18 (58·1)	22 (57·9)	124 (58·8)
Not married	58 (40·8)	13 (41·9)	16 (42·1)	87 (41·2)
Sexual orientation				
Heterosexual	136 (96·5)	31 (100·0)	35 (92·1)	202 (96·2)
Other	5 (3·5)	0 (0)	3 (7·9)	8 (3·8)
Race				
Caucasian	122 (91·0)	21 (70·0)	35 (92·1)	178 (88·1)
Other	12 (9·0)	9 (30·0)	3 (7·9)	24 (11·9)
Religion				
Reported religion	75 (52·8)	14 (45·2)	17 (44·7)	106 (50·2)
No reported religion	67 (47·2)	17 (54·8)	21 (55·3)	105 (49·8)
Religious service attendance				
Weekly or more	16 (11·3)	2 (6·5)	2 (5·3)	20 (9·5)
Less than weekly	125 (88·7)	29 (93·5)	36 (94·7)	190 (90·5)
Political voting behaviour				
Liberal	42 (29·8)	11 (35·5)	9 (23·7)	62 (29·5)
Labour	44 (31·2)	3 (9·7)	21 (55·3)	68 (32·4)
Greens	14 (9·9)	6 (19·4)	7 (18·4)	27 (12·9)
None	28 (19·9)	6 (19·4)	1 (2·6)	35 (16·7)
Other	13 (9·2)	5 (16·1)	0 (0)	18 (8·6)
Cared for child LGBT family				
Yes	118 (84·3)	24 (77·4)	20 (52·6)	162 (77·5)
Unsure or no	22 (15·7)	7 (22·6)	18 (47·4)	47 (22·5)
Friends who are openly LGBT				
Yes	119 (85·0)	23 (74·2)	35 (92·1)	177 (84·7)
No	21 (15·0)	8 (25·8)	3 (7·9)	32 (15·3)

LGBT, lesbian, gay, bisexual and transgender.

nurses (48·6%) or other staff (48·5%), but were more likely to respond that encouraging disclosure is important or useful (30·0%) compared with nurses (22·2%) and other staff (19·4%). Staff who did not encourage disclosure (55·5%) considered that it was not relevant because disclosure did not change how they delivered care.

Almost 10% of the respondents who were unsure about specifically encouraging disclosure of LGBT parenting reported feeling uncomfortable and unsure how to ask. One respondent said, '*I feel a little daunted! Don't really understand how to ask this question*'. In contrast, a respondent who works with a large number of lesbian parents said, '*They (the parents) volunteer it*'. Even if the parents do disclose, one respondent said at times, '*LGBT couples ask this not to be written formally in the chart for fear of discrimination, though they are happy to disclose verbally*'.

Forty-four per cent of respondents did not consider that lack of disclosure impacted on care because they treated all families equally. Some respondent, of note, social workers, reported that although they believed there should be no difference with nondisclosure in that, all families should receive equal care, '*it was helpful to know the relationships for advocacy and service referral purposes*'. Others were aware of possible consequences on the child of nondisclosure. One respondent said:

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Table 2 Knowledge, attitude and gay affirmative practice mean scale score comparisons* by sociodemographic variables and professional group

Scale	Knowledge mean (SD)	*p*	Attitudes mean (SD)	*p*	Gay affirmative practice mean (SD)	*p*
Gender						
Female	14·8 (2·7)	0·03	29·3 (10·5)	0·80	49·3 (8·7)	0·30
Male	15·7 (2·7)		29·4 (9·0)		48·1 (7·8)	
Highest qualification						
≤Undergraduate degree	14·8 (2·7)	0·61	28·9 (10·2)	0·35	50·0 (7·7)	0·13
Postgraduate degree+	15·0 (2·7)		29·8 (10·4)		47·7 (9·7)	
Marital status						
Not married	15·3 (2·2)	0·39	26·6 (8·0)	0·001	50·1 (8·0)	0·23
Married	14·7 (3·0)		31·2 (11·3)		48·3 (9·1)	
Race						
Caucasian	15·3 (2·3)	0·004	27·7 (7·9)	0·01	49·4 (10·8)	0·99
Other	12·5 (4·0)		37·1 (15·4)		48·7 (10·8)	
Political voting behaviour†						
Liberal	14·6 (2·6)	0·007	33·1 (12·7)	<0·001	46·8 (9·1)	0·01
Labour	15·5 (2·3)		26·3 (5·9)		50·8 (8·0)	
Greens	16·0 (2·0)		25·0 (5·9)		52·2 (6·7)	
Other	13·9 (3·2)		31·3 (11·7)		47·7 (9·2)	
Religious beliefs						
Yes	14·5 (2·7)	0·005	32·4 (12·2)	<0·001	48·5 (9·2)	0·43
No	15·4 (2·6)		26·0 (6·2)		49·7 (8·2)	
Religious beliefs						
Christian	14·6 (2·6)	0·06	31·4 (10·9)	0·001	48·6 (8·7)	0·49
Other	15·1 (2·8)		27·4 (9·3)		49·4 (8·7)	
Attend religious service						
Weekly+	12·9 (4·0)	0·03	47·5 (16·6)	<0·001	42·8 (13·1)	0·03
<Weekly	15·1 (2·4)		27·5 (7·3)		49·7 (7·9)	
Frequency pray						
Weekly+	13·8 (3·4)	0·01	38·5 (15·2)	<0·001	46·8 (10·1)	0·08
<Weekly	15·3 (2·3)		26·6 (6·1)		49·8 (8·1)	
Friends openly LGBT						
Yes	15·2 (2·4)	0·03	27·7 (8·2)	<0·001	49·8 (8·0)	0·02
No	13·5 (3·7)		39·2 (14·9)		44·6 (11·1)	
Ever cared for LGBT child						
Yes	14·9 (2·6)	0·91	29·3 (10·4)	0·078	49·4 (8·2)	0·30
No or unsure	14·8 (2·9)		29·2 (10·0)		47·5 (10·0)	
Professional group†						
Nursing	14·6 (2·5)	0·002	29·9 (11·0)	0·012	48·7 (9·6)	0·26
Medical	15·8 (2·7)		30·1 (8·7)		48·2 (6·9)	
Allied and other	15·3 (3·0)		26·7 (8·4)		51·1 (6·1)	

SD, standard deviation; LGBT, lesbian, gay, bisexual and transgender.
Higher knowledge scores indicate greater knowledge (possible range 0–19).
Higher attitude scores indicate more negative attitudes (possible range 20–80).
Higher gay affirmative practices indicate greater consistency with gay affirmative practice (possible range 15–60).
*Mann–Whitney *U*-test.
†Kruskal–Wallis one-way ANOVA.

Perhaps the child colludes in hiding up the family constellation unnecessarily and this engenders shame and difference for no good reason. If LGBT parents are loving and caring people the child deserves to feel proud of them as this is an achievement for any family.

Another respondent identified the effect on the child by saying:

It means on top of the medical issue/crisis children are being asked to hide or lie about their family composition. This gives a strong

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Table 3 Attitude mean subscale score comparisons† by selected sociodemographic variables and professional group

Scale	Attitudes to lesbians mean (SD)	*p*	Attitudes to gay men mean (SD)	*p*
Gender				
Female	13·5 (5·3)	0·73	15·9 (5·8)	0·82
Male	13·1 (3·4)		16·0 (6·3)	
Marital status				
Not married	12·7 (4·2)	0·13	14·2 (4·6)	<0·001
Married	14·0 (5·4)		17·2 (6·4)	
Race				
Caucasian	12·7 (3·9)	0·01	15·1 (4·8)	0·004
Other	17·1 (7·8)		20·4 (8·3)	
Political voting behaviour*				
Liberal	14·8 (6·1)		18·4 (6·8)	
Labour	12·0 (2·4)		14·2 (4·2)	
Greens	11·5 (2·1)		13·5 (4·2)	
Other	14·8 (6·4)		16·6 (6·2)	
Religious beliefs				
Yes	14·8 (6·1)	<0·001	17·8 (6·7)	<0·001
No	12·0 (2·8)		14·1 (4·1)	
Religious beliefs				
Christian	14·4 (5·7)	0·008	17·2 (5·9)	<0·001
Other	12·6 (4·2)		14·8 (5·6)	
Attend religious service				
Weekly+	21·6 (8·4)	<0·001	25·5 (8·8)	<0·001
<Weekly	12·6 (3·5)		15·0 (4·6)	
Frequency pray				
Weekly+	17·6 (7·5)	<0·001	20·8 (8·1)	<0·001
<Weekly	12·1 (2·7)		14·5 (4·1)	
Friends openly LGBT				
Yes	12·6 (3·7)	<0·001	15·0 (4·9)	<0·001
No	18·4 (7·8)		21·6 (7·7)	
Professional group*				
Nursing	13·9 (5·6)	0·11	16·1 (6·1)	0·28
Medical	13·3 (3·4)		16·5 (5·8)	
Allied and other	12·0 (3·5)		14·7 (5·1)	

†$p < 0.05$
*Mann–Whitney *U*-test.
Higher attitude subscale scores indicate more negative attitudes (possible range 10–40).
SD, standard deviation; LGBT, lesbian, gay, bisexual and transgender.

message of shame, guilt or dysfunction that is not psychologically healthy for the children and family.

Discussion

This study is part of a set which gives a detailed examination of experiences of LGBT parents who are seeking health care for their children and the knowledge, attitudes and beliefs of the health professionals who care for them. One qualitative study examined the experiences of lesbian women's pregnancy and birthing (Chapman *et al.* 2012b), while another explored parents' experiences of finding health care for their children. (Chapman *et al.* 2012a) Both of these studies were influenced by the fact that the parents recruited were all well educated, confident and able to navigate their way around the health system, and so their experiences were, in the main, positive. Recruitment of parents who were not so well equipped to deal with the exigencies of health systems is a project for the future and may well narrate a different story.

Other studies in this Australian series have examined the attitudes to, and knowledge about, homosexuality using the same tools as used in this current study. One study included nursing and medical university students (Chapman *et al.* 2012e) and another, staff at a second-level hospital (Chapman *et al.* 2012c), and data from community facilities are being analysed at present and will be reported separately. However, the findings to date have been consistent, regardless of site and type of institution, and support evidence from other studies from around the world.

Differences in knowledge, attitudes and affirmative practice in all studies, including this one, were strongly influenced by religion, religiosity and ethnicity, indicating the likely inter-related roles of religion and culture in shaping people's perceptions of LGBT people. Other authors have found similar effects; indeed, such results are highly characteristic of studies about homosexuality across a range of countries (Röndahl *et al.* 2004, Sanchez *et al.* 2006, Tucker & Potocky-Tripodi 2006, Dinkel *et al.* 2007). If health professionals hold such attitudes, then the delivery of care to LGBT people must be compromised. When considering the care of children, concern is raised that if parents suffer discrimination when seeking health care for their children, these children are particularly vulnerable.

Family-centred care is a wonderful ideal (Darbyshire 1994), but its effective implementation is known to be difficult (Shields *et al.* 2012a,b). In the case of families from vulnerable groups such as LGBT, with attitudes indicated by our results, such difficulties are compounded. It is normal human behaviour to delay or avoid interactions with negative or potentially hurtful experiences. It may happen that family-centred care is so compromised for these families that parents may delay or avoid taking their child to a health service, increasing the risk of adverse health outcomes.

The survey results indicated that many respondents hold beliefs that are consistent with GAP, and more positive attitudes are also associated with reporting beliefs consistent with GAP. However, nearly half of those who said there were no implications of nondisclosure said it should not matter and that families should be treated equally for need.

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Table 4 Summary of staff responses to the three open-ended questions*

Question	(%)
Question 1. Encourage disclosure	*n* = 170
Agree	34
Important, useful, helps healthcare, need to know for FCC (*family-centred care*), standard/usual practice to ask about roles	56·9
Use open questions, gender neutral language, no assumptions, no judgement, not an issue to ask, same for all family structures	36·2
Disagree	50
Not relevant, not important, no need, do not discriminate/does not change care, not applicable, not my role	55·5
Neither agree not disagree	15·9
If clinically relevant, depends on situation	5
Lead by parent disclosure, up to patient, patient can/often discloses	8·8
Intrusive, personal issue, may feel uncomfortable/offend, do not know how to ask	9·4
Question 2. Implications of nondisclosure	*n* = 159
Should not matter, all should be treated equally according to need	44·4
Confusion, embarrassment, guilt or shame, poor communication, isolation, anxiety, stress for parents and/or child	25·8
May not get required care and/or support/FCC (*family-centred care*)	15·7
Legal and consent issues, decision-making may be poorly informed	8·8
Do not know, unsure of implications (if any)	5
Question 3. Suggestions to assist health professionals to care for families	*n* = 143
Personal level	
Be open minded, nonjudgemental, respectful, accepting	39·2
Treat as any other family by individualising care for family, acknowledge parenting role, focus on parenting not gender	26·6
Institutional/educational level	
Increase awareness & understanding, education to address preconceptions/practical skills/eLearning package, address in professional standards, (*State Health*) code of conduct, have question or gender neutral question on admission and assessment forms	21

*Question 1: When taking a family social history, do you specifically encourage disclosure of possible lesbian, gay, bisexual, transgender (LGBT) parenting roles?; Question 2: What are the implications, if any, for health care provision for a child if his or her LGBT parents do not disclose their relationship?; Question 3: What suggestions do you have that might assist health professionals to care for/manage children of LGBT families?.

While this is an excellent basis for providing care, it does not necessarily translate into affirmative action for vulnerable groups. This assertion may result from lack of knowledge about the effects of nondisclosure on families. There was a weak positive correlation between knowledge scores and GAP scores. However increased knowledge is associated with more positive attitudes suggesting some attitudinal shift may be possible with education, and this may be reflected in improved GAP scores.

Similar to our other findings, the medical respondents in this current study demonstrated higher levels of knowledge regarding LGBT factors than other professions (Chapman *et al.* 2012a,b). However, this knowledge does not necessarily translate into a more accepting attitude towards LGBT people, and nontraditional and innovative methods may be required to change staff practices to ensure that children do not miss out or receive delayed care. Interventions such as software applications ('Apps') delivered via mobile technologies could be used to provide instant information and diversity reminders for health professionals who communicate with LGBT families, and such interventions, as well as education packages, are under development at present. These will be trialled in the LGBT community and with health professionals from different disciplines and in a variety of settings.

Limitations

One of the major limitations in this study is the use of a convenience sample, which limits the generalisability of the findings. Based on the descriptive aim of this research, we chose not to adjust for multiple comparisons. As such, due to the multiple comparisons performed, some associations may have been found by chance. However, our findings are consistent with other studies in similar settings (Röndahl *et al.* 2004, Crisp 2006, Chapman *et al.* 2012c), which provides support for the validity of these findings, and some evidence of consistency across secondary and tertiary settings.

Conclusion

In conclusion, this study of health professionals working in a tertiary paediatric hospital setting with family-centred care models in place did identify opportunities for improvement in health professional knowledge and attitudes that may ultimately impact the experience of hospitalisation for LGBT parents and the quality of care received by their children.

Relevance to clinical practice

The findings of this study have revealed similarities in the knowledge, attitude and beliefs of staff working in

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paediatric tertiary hospitals compared with those in secondary-level settings towards LGBT parents. This finding is significant considering that inferences can be made about the level of family-centred care policies and guidelines adopted in these institutions and the amount of exposure staff working in these facilities have to diverse and nontraditional families.

We have previously argued for the inclusion of relevant education programmes at both an undergraduate and postgraduate levels. However, in addition to formal programmes and to ensure that LGBT parents and their families are provided with holistic, equitable high-quality care, it is important that health professionals have easy and instant access to up-to-date information and reminders to assist them in effectively communicating with this vulnerable population. A promising idea with potential that needs investigation is to explore the efficacy of the use of technology, such as an individuals' access to mobile technologies like smart phones, in providing this information 'just in time' to clinicians while at the bedside or during a consultation. Hospital management, educators, researchers and clinicians may need to be 'thinking out of the square' and making better use of current and future technologies to improve the experience of all families seeking health care for their children.

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Disclosure

The authors have confirmed that all authors meet the ICMJE criteria for authorship credit (www.icmje.org/ethical_1author.html), as follows: (1) substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data; (2) drafting the article or revising it critically for important intellectual content; and (3) final approval of the version to be published.

Conflict of interest

The authors have no conflicts of conflicts of interest to declare.

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